understand when condoms are not used, among whom, and why before it is possible to design a feasible intervention.[4]

It should not be forgotten that the scale of qualitative research is also its strength, enabling an understanding of interactions between host, pathogen, and environment over time and in the context of relevant variables such as relationships with sexual partners and service use. These advantages tend to be lost in studies of large numbers and so it is preferable to employ one of the analytic techniques available for generalising findings about social relationships concerning class, network, sex, and so forth to "scale up" findings of this kind. Further development of these markers will make it possible to achieve greater integration between complementary studies of the biological and social, the qualitative and the quantitative.

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Editor's note: See also paper by Scoular *et al*, p 340–3.

Destigmatising STIs: remaining challenges, new opportunities

The potential barriers to attendance at specialist sexually transmitted infection (STI) services have long been recognised. The Royal Commission report in 1916 advised that to be effective, services needed to be "skilled, free . . . and provided at the earliest possible moment." In addition, clinicians needed to be aware of "the fear of disgrace and the consequent desire for concealment" that could hamper treatment delivery.[1] In many respects the UK GUM services have risen to these challenges. The majority of clinics provide timely, effective care from easy to access and well located clinics.[2] We are successful at attracting new referrals and have seen a year on year increase in voluntary attendances with a record 1.5 million consultations in 1999. With this level of success it would be easy to conclude that STI services are both accessible and acceptable for at least the majority of the UK population. However, it would appear that many patients with known or suspected STIs are still reluctant to attend genitourinary medicine (GUM) clinics for care. The principal suspected reason for this is the stigma associated with an STI diagnosis, which may be reinforced by the need for attendance at GUM clinics.[3] In this regard, genitourinary medicine has much in common with mental health and cancer services. However, GUM specialists particularly value open access and strive to provide a confidential, non-judgmental, and supportive service, so it is particularly galling for them that a visit to a GUM clinic should be viewed as stigmatising by many potential users.

In looking at the possible consequences of stigma on health seeking behaviour it is helpful to look at its constituent components. It is generally considered that two elements exist—"felt" stigma, which is determined by an individual's background, education, and personal experiences and "enacted" stigma, the direct consequence of those around them discovering their problem, and resulting in discrimination. The levels of stigma attached to a particular behaviour or illness are not fixed; they vary between cultures and historically. There is some evidence that within modern culture, those conditions, which are to some extent behaviour related, attract most stigma. Importantly though, both felt and enacted stigma are amenable to public education campaigns.[4]

In this issue of *Sexually Transmitted Infections* (p 340) Scoular *et al* examine the experience and evolution of stigma among young women recently diagnosed with chlamydial infections initially outside a GUM setting. This is an important paper because although it is recognised that the stigma associated with GUM clinics is a barrier to patient access, the question of how modern GUM services can work to modify individuals' experiences of stigma associated with STIs has been largely ignored. Using a qualitative approach with semistructured interviews the authors provide a useful insight into how people feel about being diagnosed with an STI and their experience attending a GUM clinic. These participants had often not disclosed their intended visit to others and fear, isolation, and secrecy pervaded the consultation. Gratifyingly, although a GUM clinic visit was experienced as a stressful event, these study patients did not have their worst fears recognised and some even looked upon it as a positive experience. A process of normalisation and acceptance of information provided by clinic staff resulted in these young women overcoming initial reservations about attending a GUM clinic.

The second important finding of this paper was a comparison of how these individuals viewed GUM services and a family planning clinic (FPC). The GUM clinic was viewed as more "dangerous" than family planning services, which had a more benign appeal. The FPC was valued because it appeared to be associated with a perceived distance from a "disease model" of health care. There was no embarrassment or shame associated with the FPC; however, the GUM clinic was seen as being only attended by individuals who possessed traits that were deemed to be socially and morally unacceptable. It was "normal" for young women to attend an FPC but a GUM clinic existed for "others."

So what are the challenges and tasks for those working in GUM services and those responsible for directing policy? A role of the GUM physician in the education of other healthcare professionals and the general population seems to be a key issue in destigmatising GUM clinics. The respondents in this study had very little knowledge or understanding of STIs and the scale and difficulty of the task should not be underestimated. Previous public health strategies focusing attention on "high risk" individuals have probably intensified the marginalisation and stigma associated with STIs and GUM clinics. Ignorance of STIs and the role of genitourinary medicine are not confined to the lay public and pervade many areas of health care. Many workers in frontline services are reluctant to suggest to their patients that they attend a GUM clinic in case the patient is offended at the inference. The Monks report has gone some way to address stigma by moving clinics from obscure areas of the hospital into the centre of the main hospitals and currently we have unique opportunities to

educate others about the role and place of GUM services.[5] The recent Department of Health chlamydia pilot study has shown that the rates of chlamydial infection are almost identical in those 19–24 year olds attending a GUM clinic as those asymptomatic 19–24 year olds attending a GP surgery with an unrelated problem.[6] STIs can no longer be viewed as the special problems of self referrers to GUM clinics, and will have to be seen as an important component of primary health care. The introduction of universal HIV antibody testing into antenatal clinics will undoubtedly raise awareness of STIs in both pregnant women and antenatal clinic staff.[7] We need to capitalise on these events and use them to break down the prejudices that exist for individuals with STIs and GUM clinics. Healthcare workers will need to develop skills in raising the subject of sexual health, in communicating the presence of disease and the need for effective management—probably involving referral to genitourinary medicine services. Clinicians will need to be able to communicate the positive nature of an early diagnosis and the ease with which STIs can be acquired, without losing sight of the opportunities in reducing risk of further disease acquisition. In addition, closer working and some integration across different sexual health services may provide choice for patients unwilling to attend traditional GUM services.

We should feel encouraged that the experience for an individual visiting a GUM clinic is generally positive, and not as bad as is often anticipated. However, we must endeavour that as our service becomes stretched and increasing demands are made on our time, we do not allow an individual to feel let down by the service we offer. Giving patients adequate time in the clinic setting to explore their feelings and to help unravel the felt stigma they may have developed must be an essential part of our job.

The surest way to end stigma related to STI is to find effective means of identifying, eradicating, and preventing infection. Until that time we must acknowledge the importance of an all too human response to circumstances.

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Oral sex and HIV transmission

It is well established that oral sex may lead to the transmission of a wide variety of STIs, including HIV.[1–4] As discussed elsewhere in this issue (see syphilis symposium, pp 309–26) oral sex appears to be important in the resurgence of early infectious syphilis in the United Kingdom. Many of these latter cases have been in HIV positive individuals and it is likely that co-infection with syphilis would increase the risk of (oral) transmission of HIV—as has been shown similarly in numerous studies of genital HIV/STI co-infection.

Despite recognising that transmission does occur, some feel that the underlying risk of HIV transmission via oral sex is so low as to be negligible. However, two recent studies (as yet unpublished in peer review journals) suggest that oral sex may be contributing to a higher proportion of new HIV infections than previously thought. In the first study, of 102 men who had recently seroconverted, eight (7.8%) were attributed to oral sex. Of these eight, unprotected oral sex was the only risk factor in four, but four had also had protected anal sex.[5] A second study from my own unit was of 494 HIV positive patients (mostly homosexual) who completed a questionnaire on sexual behaviour. Six per cent believed themselves to have been infected because of oral sex alone. Further follow up of these and other patients in our unit, who believe themselves to have been infected by unprotected oral sex is ongoing and about half, where data are available, have had recurrent infections of the mouth, which could have increased their risk.[6]

A third report of two studies from Australia, gave contradictory results. An interview study found that a similar proportion, seven of 75 (9.3%), homosexual men gave receptive oral intercourse as the likely source of their infection. However, the investigators felt that they must have had other risk factors as they denied ejaculation as part of their oral sex. Furthermore, in a cohort study of over 700 men, 26% reported unprotected receptive oral intercourse with ejaculation but they did not have an increased risk of seroconversion[7] (for further discussion, see CDR[8])

Finally, the press release from a very recent report of an ongoing study of homosexual men from San Francisco states that receptive oral intercourse with ejaculation was a very low risk. One seroconversion was found but thought to have occurred outside the study period. However, the study population was small (198), only 20% of these claimed to have had receptive oral sex with an HIV positive partner, only 40% to ejaculation, and follow up was for only 6 months. It is therefore unlikely such a study would have had sufficient power to detect transmission, or to reject the hypothesis that transmission does occur (presented by Dr Kimberly Page-Shafer *et al*, National HIV prevention conference, Atlanta, August 2001).

In June 2000, the Department of Health, following the deliberations of a working party of the chief medical officers' expert advisory group on AIDS (EAGA), published a document entitled "Review of the evidence on the risk of HIV transmission associated with oral sex."[9] The authors concluded, as with other extensive reviews, that oral transmission of HIV occurs and that certain factors might increase the risk. These include receptive oral intercourse (ROI) with ejaculation, high viral load, and various factors which might breach the oral defence mechanisms. Saliva is protective and has a number of antiviral components, such as thrombospondin and secretory leucocyte protease inhibitor (SLPI), but these are likely to be overcome by the volume effects of seminal fluid.[10]

Although most of the several dozen case reports to date have been of receptive oral intercourse, it should be noted